

MAIL TO:

Blue Cross and Blue Shield of Florida Spending Account Administration P.O. Box 45132 Jacksonville, FL 32232-5132 (800) 753-4681

Social Security Number:

Health Expense Reimbursement Request Form

Employee's Name: (Last Name, First Name, Middle Initial)

For Health Care Flexible Spending Accounts (FSAs) and Health Reimbursement Accounts (HRAs)

PLEASE PRINT AND COMPLETE THIS FORM IN ITS ENTIRETY. INCOMPLETE FORMS WILL BE RETURNED.

Complete the information below for out of pocket Health Care Expenses incurred by you and your eligible dependents. Eligible dependents are defined by your employer and must meet the definition of dependent as defined by the IRS for tax reporting purposes. You **must** provide an Explanation of Benefits from your Health Plan, if applicable, indicating the amount of the expense you are obligated to pay **or** a written statement, bill or receipt from an independent third party, such as an insurance company, doctor or other health care provider, indicating the date and type of medical expense that has been incurred and the amount of such expense (canceled checks will not be accepted). Only list the amounts you have to pay, (your out-of-pocket expense), after insurance, if applicable, pays its share. Please sign and date the form, then send it along with your proof of expense documentation. **Balance forward/due or generic "cash receipts" are not acceptable.**

Specify which account(s) you participate in:	Employer's Name:					1		
Other: Please specify	Specify which account	(s) you par	rticipate in:	Health Care F	SA 🗆 HRA	☐ Both		
Dependent Information Are any of your dependents college students under age 25?	Type of Health Plan(s).	Check all	that apply:	PPO Health	HMO Health	☐ Pharmacy ☐ De	ental 🗆 Vision 🗅	None
Are any of your dependents college students under age 25?	☐ Other: Please specify			Note:	lf unsure, you m	ay enclose a copy o	your ID card(s).	
Does the dependent(s) you are claiming live in your household?				Dependent	Information			
Reimbursement For Health Care Expenses Patient / Dependent's Birth Date Date of Service Service Amount Date Of Service Provider Use Only Example: Pat Roe 10/3/55 Self 4/9/02 \$15.00 Doctor Visit Dr. John Smith Self Algorithm Service Date Service Service Amount Doctor Visit Dr. John Smith Service Manual Doctor Visit Dr. John Smith Self Algorithm Service Date Service Service Amount Doctor Visit Dr. John Smith Self Algorithm Service Service Service Service Name of Service Provider Use Only Semple: Pat Roe 10/3/55 Self Algorithm Service Service Name of Service Date Service Date Service Name of Service Name of Service Name of Service Date Service Name of Service Date Service Name of Service Name	Are any of your depende	ents college	students under	age 25?	Yes □ No			
Reimbursement For Health Care Expenses Patient / Dependent's Birth Relationship Date of To Employee Service' Amount Type of Service Name of Service Use Only Example: Pat Roe 10/3/55 Self 4/9/02 \$15.00 Doctor Visit Dr. John Smith \$ Doctor Visit Dr. John Smith \$ Dr. John Smith \$ Dr. John Smith \$ Service must be totally rendered and completed before payment on any part can be made. Service must be totally rendered and completed before payment on any part can be made. Employee Signature Required Below	Does the dependent(s) y	ou are clai	ming live in your	household?	☐ Yes ☐ No)		
Patient / Dependent's First & Last Name Date To Employee Service Service Amount Type of Service Name of Service Use Only Self 4/9/02 \$15.00 Doctor Visit Dr. John Smith	Do you provide more that	an one-half	of the support fo	r the dependen	t(s) during the ye	ear? 🛚 Yes 🔻	No	
First & Last Name Date To Employee Service* Amount Provider Use Only \$ 15.00 Doctor Visit Dr. John Smith S *Service must be totally rendered and completed before payment on any part can be made. Employee Signature Required Below I certify that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while I was a participant under my company's Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) plans administered by Blue Cross and Blue Shield of Florida (BCBSF); and that such expenses have not been reimbursed, and are not reish and the HRA plans that reimbursement will be made from the FSA first, when the expense is eligible under both plans. I understand that I alone am fully responsible for the sufficiency, accuracy and variety in Information I provide relating to this reimbursement request, and that unless an expense of which reimbursement is dialined by a such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made. I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. Employee Signature: Day Phone #: Date: Processor's Name: Date:				rsement For				
\$ Service must be totally rendered and completed before TOTAL \$ Service must be totally rendered and completed before TOTAL \$ Employee Signature Required Below I certify that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while I was a participant under my company's Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) plans administered by Blue Cross and Blue Shield of Florida (BCSSF); and that such expenses have not been reimbursed, and are not rembursable, under any other health plan coverage, other insurance, or from any other source. I understand that if I participate in both the Health Care FSA and the HRA plans that reimbursement will be made from the FSA first, when the expense is eligible under both plans. I understand that I alone am fully responsible for the sufficiency, accuracy and veracity of all information I provide relating to this reimbursement request; and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made. I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. Employee Signature: Day Phone #: Date: FOR BCBSF USE ONLY Request ID: Date Processor's Name: Date Processor's Name: Date:			To Employee			Type of Service		
*Service must be totally rendered and completed before payment on any part can be made. *Employee Signature Required Below I certify that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while I was a participant under my company's Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) plans administered by Blue Cross and Blue Shield of Florida (BCBSF); and that such expenses have not been reimbursed, and are not reimbursable, under any other health plan coverage, other insurance, or from any other source. I understand that if I participate in both the Health Care FSA and the HRA plans that reimbursement will be made from the FSA first, when the expense is eligible under tool the reimbursement of all information I provide relating to this reimbursement request; and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made. I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. Employee Signature: Day Phone #: Date: Processor's Name: Date Processed:	Example: Pat Roe	10/3/55	Self	4/9/02		Doctor Visit	Dr. John Smith	
*Service must be totally rendered and completed before payment on any part can be made. **Employee Signature Required Below** Certify that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while I was a participant under my company's Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) plans administered by Blue Cross and Blue Shield of Florida (BCBSF); and that such expenses have not been reimbursed, and are not reimbursable, under any other health plan coverage, other insurance, or from any other source. I understand that if I participate in both the Health Care FSA and the HRA plans that reimbursement will be made from the FSA first, when the expense is eligible under both plans. I understand that I alone am fully responsible for the sufficiency, accuracy and veracity of all information I provide relating to this reimbursement request; and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made. I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. Employee Signature:					\$			
*Service must be totally rendered and completed before payment on any part can be made. **Employee Signature Required Below** Certify that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while I was a participant under my company's Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) plans administered by Blue Cross and Blue Shield of Florida (BCBSF); and that such expenses have not been reimbursed, and are not reimbursable, under any other health plan coverage, other insurance, or from any other source. I understand that if I participate in both the Health Care FSA and the HRA plans that reimbursement will be made from the FSA first, when the expense is eligible under both plans. I understand that I alone am fully responsible for the sufficiency, accuracy and veracity of all information I provide relating to this reimbursement request; and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made. I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. Employee Signature:								
*Service must be totally rendered and completed before payment on any part can be made. *Employee Signature Required Below I certify that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while I was a participant under my company's Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) plans administered by Blue Cross and Blue Shield of Florida (BCBSF); and that such expenses have not been reimbursed, and are not reimbursable, under any other health plan coverage, other insurance, or from any other source. I understand that if I participate in both the Health Care FSA and the HRA plans that reimbursement will be made from the FSA first, when the expense is eligible under both plans. I understand that I alone am fully responsible for the sufficiency, accuracy and veracity of all information I provide relating to this reimbursement request; and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made. I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. **Employee Signature:					\$			
*Service must be totally rendered and completed before payment on any part can be made. *Employee Signature Required Below I certify that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while I was a participant under my company's Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) plans administered by Blue Cross and Blue Shield of Florida (BCBSF); and that such expenses have not been reimbursed, and are not reimbursable, under any other health plan coverage, other insurance, or from any other source. I understand that if I participate in both the Health Care FSA and the HRA plans that reimbursement will be made from the FSA first, when the expense is eligible under both plans. I understand that I alone am fully responsible for the sufficiency, accuracy and veracity of all information I provide relating to this reimbursement request; and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made. I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. **Employee Signature:					¢			
*Service must be totally rendered and completed before payment on any part can be made. **Employee Signature Required Below** Certify that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while I was a participant under my company's Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) plans administered by Blue Cross and Blue Shield of Florida (BCBSF); and that such expenses have not been reimbursed, and are not reimbursable, under any other health plan coverage, other insurance, or from any other source. I understand that if I participate in both the Health Care FSA and the HRA plans that reimbursement will be made from the FSA first, when the expense is eligible under both plans. I understand that I alone am fully responsible for the sufficiency, accuracy and veracity of all information I provide relating to this reimbursement request; and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made. I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. Day Phone #:					Ψ			
*Service must be totally rendered and completed before payment on any part can be made. **Employee Signature Required Below** Certify that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while I was a participant under my company's Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) plans administered by Blue Cross and Blue Shield of Florida (BCBSF); and that such expenses have not been reimbursed, and are not reimbursable, under any other health plan coverage, other insurance, or from any other source. I understand that if I participate in both the Health Care FSA and the HRA plans that reimbursement will be made from the FSA first, when the expense is eligible under both plans. I understand that I alone am fully responsible for the sufficiency, accuracy and veracity of all information I provide relating to this reimbursement request; and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made. I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. Day Phone #:								
*Service must be totally rendered and completed before payment on any part can be made. Certify that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while I was a participant under my company's Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) plans administered by Blue Cross and Blue Shield of Florida (BCBSF); and that such expenses have not been reimbursed, and are not reimbursable, under any other health plan coverage, other insurance, or from any other source. I understand that if I participate in both the Health Care FSA and the HRA plans that reimbursement will be made from the FSA first, when the expense is eligible under both plans. I understand that I alone am fully responsible for the sufficiency, accuracy and veracity of all information I provide relating to this reimbursement request; and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made. I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. Day Phone #:					\$			
Employee Signature Required Below I certify that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while I was a participant under my company's Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) plans administered by Blue Cross and Blue Shield of Florida (BCBSF); and that such expenses have not been reimbursed, and are not reimbursable, under any other health plan coverage, other insurance, or from any other source. I understand that if I participate in both the Health Care FSA and the HRA plans that reimbursement will be made from the FSA first, when the expense is eligible under both plans. I understand that I alone am fully responsible for the sufficiency, accuracy and veracity of all information I provide relating to this reimbursement request; and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made. I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. Employee Signature: Day Phone #: Date Processed: Date Processed: Date Processed:					\$			
Employee Signature Required Below I certify that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while I was a participant under my company's Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) plans administered by Blue Cross and Blue Shield of Florida (BCBSF); and that such expenses have not been reimbursed, and are not reimbursable, under any other health plan coverage, other insurance, or from any other source. I understand that if I participate in both the Health Care FSA and the HRA plans that reimbursement will be made from the FSA first, when the expense is eligible under both plans. I understand that I alone am fully responsible for the sufficiency, accuracy and veracity of all information I provide relating to this reimbursement request; and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made. I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. Employee Signature: Day Phone #: Date Processed: Date Processed: Date Processed:	*Service must be totally ren	dered and co	ompleted before	TOTAL	\$			
I certify that all expenses for which reimbursement or payment is claimed by submission of this form, were incurred during a period while I was a participant under my company's Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) plans administered by Blue Cross and Blue Shield of Florida (BCBSF); and that such expenses have not been reimbursed, and are not reimbursable, under any other health plan coverage, other insurance, or from any other source. I understand that if I participate in both the Health Care FSA and the HRA plans that reimbursement will be made from the FSA first, when the expense is eligible under both plans. I understand that I alone am fully responsible for the sufficiency, accuracy and veracity of all information I provide relating to this reimbursement request; and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made. I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. Employee Signature: Day Phone #: Date: Date: Date: Date Processed: Date Processed:	payment on any part can be	e made.	·	-				
participant under my company's Flexible Spending Account (FSA) and/or Health Reimbursement Account (HRA) plans administered by Blue Cross and Blue Shield of Florida (BCBSF); and that such expenses have not been reimbursed, and are not reimbursable, under any other health plan coverage, other insurance, or from any other source. I understand that if I participate in both the Health Care FSA and the HRA plans that reimbursement will be made from the FSA first, when the expense is eligible under both plans. I understand that I alone am fully responsible for the sufficiency, accuracy and veracity of all information I provide relating to this reimbursement request; and that unless an expense for which reimbursement is claimed is a proper expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made. I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. Employee Signature: Day Phone #: Date: Date: Date: Date: Date: Date: Date: Date Processed:			Emp	loyee Signat	ure Required	Below		
expense under the Plan, I may be liable for the payment of all related taxes including Federal, state or city income on paid amounts which relate to such expense. I further understand that no separate Federal income tax deduction or credit is permitted for amounts for which reimbursement is made. I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. Employee Signature: Day Phone #: Date: FOR BCBSF USE ONLY Processor's Name: Date Processed:	participant under my compa Blue Shield of Florida (BCB other insurance, or from an made from the FSA first, wh	any's Flexible SF); and tha y other sourc nen the expe	e Spending Accour t such expenses h ce. I understand than nse is eligible under	nt (FSA) and/or H ave not been rein at if I participate in er both plans. I u	ealth Reimbursem nbursed, and are r n both the Health (nderstand that I al	ent Account (HRA) pla not reimbursable, under Care FSA and the HRA one am fully responsib	ns administered by Blue r any other health plan of plans that reimbursem e for the sufficiency, ac	e Cross and coverage, ent will be curacy and
I hereby authorize any individual or organization to release any information requested by BCBSF with respect the claims on this specific application. Employee Signature: Day Phone #: FOR BCBSF USE ONLY Processor's Name: Date Processed:	expense under the Plan, I n	nay be liable	for the payment of	f all related taxes	including Federal,	state or city income or	n paid amounts which re	elate to
FOR BCBSF USE ONLY Processor's Name: Request ID: Date Processed:	·		•			•		
Processor's Name: Request ID: Date Processed:	Employee Signatu	re:			_ Day Phon	e #:	Date: _	
			_					
	Processor's Name:		Reque	st ID:	D:	ate Processed:		